Current Research Journal of Social Sciences 10(1): 9-17, 2019
DOI:10.19026/crjss.10.5989
ISSN: 2041-3238, e-ISSN: 2041-3246

Submitted: July 5, 2018 Accepted: July 31, 2018 Published: January 25, 2019

Research Article

Users' Perspectives on Community Engagement in Local Health Governance Structures in Itilima and Bariadi District Councils in Simiyu Region, Tanzania

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Abstract: The aim of this study is to investigate users' perspectives on community engagement in the health governance structures at the sub-district levels in two rural districts in Tanzania. The specific objectives of the study are: i) to examine health service users' awareness about the existence of local health governance structures, ii) to examine the level of community engagement and functionality of the structures, and iii) to identify the contextual factors affecting the functionality of local health governance structures. The study draws on empirical data collected from 281 service users, health service boards and committees' members and key informants through questionnaire survey, focus group discussions and semi-structured interviews. The study found limited health service users' awareness about the existence of health governance structures partly because some health facilities lacked the boards and committees and in some cases community members were not involved in the selection of community representatives through their village assemblies. Further, most of the community health governance structures were not functional as had infrequent meetings and varied composition contrary to the guidelines for their establishment. Consequently, community engagement in these structures was very limited. The factors affecting functionality of these structures included lack of clarity among stakeholders on the procedures for establishing the structures, limited capacity of community members on their roles and responsibilities in the structures and delays in establishing and replacing expired service boards and committees. It is concluded that, the purpose of improving healthcare service delivery through improved community participation and governance in the local health governance structures is still far from being realised. Thus, the district councils should strengthen the functionality of the health governance structures by creating awareness among stakeholders at the ward, village and health facility levels about the guidelines for establishing and functioning of the health governance structures.

Keywords: Committees, community engagement, decentralization, health governance structures, service boards, users' perspective

INTRODUCTION

Community engagement in health has been promoted as a strategy for strengthening health systems and improving health services delivery for many decades (Ramiro *et al*., 2001; McCoy *et al*., 2011). The World Health Organization defines community engagement as a process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes (WHO, 2017). Back in 1978, community engagement was identified as a fundamental component of primary health care in the Alma Ata Declaration and paved the way for broad support for community participation, engagement and mobilization in health, when world leaders agreed that "the people have the right and duty to participate individually and collectively in the planning and implementation of their health care (WHO, 1978). It is argued that the potential benefits of engaging the community in health service delivery are many, for both the community and the health system. They include: expanding coverage of health care, greater community understanding of health issues and local priorities, improved community satisfaction, greater community ownership and investment, more responsive health services, greater accountability for public funds and improved quality of health services (Dodgson *et al*., 2002; Boon, 2007; McCoy *et al*., 2011; Brinkerhoff, 2012).

Over the past few decades, also as part of decentralisation reforms, which have come to be associated with community participation and governance in many developing countries (Brinkerhoff, 2012), community engagement in health has been structured and implemented in many different forms. One of such forms is the use of health governance structures (McCoy *et al*., 2011; Kessy, 2014).

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According to McCoy *et al*. (2011), health governance structures include any formally constituted structures with community representation that have explicit link to a health facility and whose primary purpose is to enable community participation with the aims of improving health service provision and health outcomes. In different countries and contexts, these governance structures have been referred to in various ways such as: health service committees (Nathan *et al*., 2010), health facility committees (McCoy *et al*., 2011) or local health service boards (Ramiro *et al*., 2001; Saltman *et al*., 2007). Regardless of the nomenclature, community engagement in health governance structures recognizes that communities are not simply supply-side partners, but as governance actors who play a role in the demand side of health governance. They do so by fulfilling functions that contribute to service provider responsiveness and accountability, as well as to service quality. In this, health governance structures are viewed as a higher level of participation where communities are actively engaged in expressing their preferences as consumers and voters, providing input to health decisions and exercising their rights as citizens (Brinkerhoff, 2012). However, as Conyers (2007) cautions, the effectiveness of management and user committees depends on their structure, composition, motivation and capacity of their members and how they are linked to the local and national structures.

Tanzania fits well into this global picture. Since the 1990s, the country has implemented major health sector reforms including decentralization of primary health care services to local government authorities. The main strategy of these reforms has been to devolve administration and management of health services to local authorities by introducing health governance structures at local government (city, municipal, town or district council), community and health facility levels (Boon, 2007; URT, 2007; Kessy, 2014; Masanyiwa *et al*., 2015). A major objective of these health governance structures is to ensure greater participation of communities in planning and budgeting processes, as well as in the implementation of programs to improve access to quality health services and to monitor service provision at the local level (Kessy, 2014). At the council levels, these structures include the Council Health Service Boards (CHSBs) and Council Health Management Teams (CHMTs). At the health facility level, the structures are Hospital Governing Committees (HGCs), Health Centre Committees (HCCs) and Dispensary Committees (DCs) whereas those at community level are ward and village health committees (URT, 2001). Except for the CHMTs, which are composed of health staff only, all other boards and committees have mixed membership with government, voluntary agencies, private for-profit health providers and community representatives.

Previous studies in Tanzania and elsewhere show mixed results on the expected impact of health governance structures on community participation and improved health outcomes (e.g., Boon, 2007; Nathan *et al*., 2010; Maluka *et al*., 2010; McCoy *et al*., 2011; Masanyiwa *et al*., 2013; Kessy, 2014). However, most studies in Tanzania have focused on the impact of health boards and committees at the district or council level on health care services (e.g. Boon, 2007: Maluka *et al*., 2010; Kessy, 2014). Thus, there is paucity of information on community participation and functionality of these decentralised structures at the sub-district levels, especially from the users' perspectives. Therefore, the extent to which these structures have contributed to enhancing community participation in health care services delivery, is a question that warrants investigation. This study pursues this question by investigating users' perspectives on community engagement in the health governance structures at the sub-district levels. The specific objectives of the study are threefold:

- To examine service users' awareness about the existence of local health governance structures
- To examine the level of community engagement and functionality of local health governance structures
- To identify the contextual factors affecting the functionality of local health governance structures.

MATERIALS AND METHODS

The data presented in this study are based on a field study that was conducted in the rural districts of Bariadi and Itilima in Simiyu Region, northwestern Tanzania. Although the two districts cannot be claimed to be representative of all Local Government Authorities (LGAs) in Tanzania, they were purposively selected as cases to examine the experiences of decentralised health governance structures in a specific context. The two districts were formerly one before their split in 2012. Administratively, Bariadi district is divided into 3 divisions, 15 wards and 70 villages. With a population of 267,296 people (127,870 males and 139,426 females), the district has a population annual population growth rate of 3.0% and an average household size of 7.1 (URT, 2013a). In 2016, the district had 25 dispensaries and one rural health centre. Itilima is a newly established district which is administratively divided into 4 divisions, 22 wards and 102 villages. The district has a population of 313,900 people: 148,502 males and 165,398 females, with an average of 7.2 people per household and an annual growth rate of 2.9% (URT, 2013a). In terms of health service infrastructure, the district does not have a district hospital and uses Bariadi Town Hospital as a referral site. It has 30 health facilities, including three health centres and 27 dispensaries.

This study adopted a cross sectional design using mixed methods of data collection. Data were collected

at a single point in time, which is one the characteristic features of a cross sectional design. Primary and secondary data of quantitative and qualitative nature were collected to address the study objectives. Primary data were collected from health service users (community members), health facility in-charges and community health governance structures. Secondary data were collected through review and analysis of the relevant available data from District Medical Officers (DMOs), health facilities and health governance structures.

This study employed multistage sampling technique using a combination of purposive and random sampling techniques. The first stage involved purposive selection of six villages (three in each district) based on availability of health facilities in the villages. Thus, the selected villages included two with functioning dispensaries, two with rural health centres and another two without any health facilities. In addition, the selected villages were geographically sparse to ensure the diverse geographical representation of the villages within their respective districts. The second stage entailed selection of health service users either randomly or using convenience sampling techniques. In villages without health facilities, service users were visited in their households through systematic random sampling using village and *kitongoji*[i] registers. In villages with health facilities, convenience or incidental sampling technique was used by interviewing selected users that were found at the health facility. In each village, a minimum of 40 health service users participated in the survey. This is in line with Grinnell's (2001) proposal of having a minimum of 30 respondents per each category, which is sufficient to provide reasonable control over sampling error. Purposive sampling technique was used to obtain the focus group discussions' participants and key informants.

The study used mixed methods of data collection from multiple sources of evidence so as to get deeper insights into the status of community participation in health service delivery and the capacity of local governance structures in managing health services. The use of mixed methods of data collection also aimed at enhancing the reliability and validity of the study findings. A survey was conducted among 281 health service users (128 men and 153 women) using a structured questionnaire with both closed and open-ended questions. The questionnaire was designed to capture information and health service users' views and perspectives in relation to their socio-demographic characteristics, awareness, participation and functionality of the health governance structures. Further, nine FGDs were conducted, including two with dispensary governing committees, one health centre governing committee, two ward health committees and four village health committees. FGDs were useful in exploring peoples' perceptions, experiences and understanding on the issues under investigation, since they call for participants to interact with one another in formulating responses (Lynch, 2013). In addition, semi-structured interviews were held with key informants at district, ward and village levels, including DMOs, council health secretaries, in-charges of the health facilities, community health workers and village leaders. Relevant documents at the district, ward, village and health facility level such as the Comprehensive Council Health Plans (CCHPs) were also reviewed to provide secondary data.

Quantitative data collected through questionnaire survey was edited, coded and entered in the Statistical Package for Social Sciences (SPSS) to make them amenable for analysis and subsequently analyzed for descriptive statistics and chi-square tests. The qualitative data were transcribed and analyzed using qualitative content analysis, which involved transcribing the field notes from interviews and FGDs and reading through the field notes and transcripts to identify key themes and patterns relevant to the study objectives. Because quantitative and qualitative data are mutually dependent and tend to complement each other, the presentation and discussion of the findings attempts to weave together the quantitative and qualitative data.

RESULTS AND DISCUSSION

Characteristics of survey respondents: The survey findings in Table 1 show that more than half of the survey respondents (54%) were females and 46% were males. The plan was to have an equal representation of male and female respondents. However, it turned out that in many of the surveyed households, it was the adult female members who were found at home at the time their household was visited for the survey. Similarly, more female than male service users were found at the health facilities. This reflects the fact that women tend to use health services more frequently than men due to their biological-based health needs and their reproductive gender roles as the main care givers in their households (Vlassoff and Moreno, 2002; Masanyiwa *et al*., 2015).

There were more male-headed (72%) than female-headed households (28%). Close to two-thirds (64%) of the surveyed households had 7 or more members, one-fourth (25%) had between 4 to 6 members and about one-tenth (11%) had 1 to 3 members. The average household size was 8.2 persons, although households in Itilima were larger (8.5 persons) than in Bariadi (7.9). Male-headed households were also larger (8.3) than female-headed households (7.9). Overall, household sizes in the study villages were larger than the respective district averages of 7.2 and 7.1 for Itilima

Table 1: Characteristics of survey respondents (n = 281)

Variable	Categories	Bariadi	Itilima	Total	Chi-square values
Sex of respondents	Male	56(40.6)	72(50.3)	128(45.6)	$X^2 = 2.703$
	Female	82(59.4)	71(49.7)	153(54.4)	df = 1, $p = 0.100$
Household	Male headed	97(70.3)	105(73.4)	202(71.9)	$X^2 = 0.342$
headship	Female headed	41(29.7)	38(26.6)	79(28.1)	df = 1, $p = 0.559$
Household size	1-3 members	21(15.2)	10(7.0)	31(11.0)	
	4-6 members	31(22.5)	38(26.6)	69(24.6)	$X^2 = 4.973$
	7+ members	86(6.3)	95(66.4)	181(64.4)	df = 1, $p = 0.083$
	Mean household size	7.9	8.5	8.2	
Marital status	Married	109(79.0)	112(78.3)	221(78.6)	
	Single	15(10.9)	12(8.4)	27(9.6)	$X^2 = 4.453$
	Widowed	8(5.8)	16(11.2)	24(8.5)	df = 1, $p = 0.348$
	Separated	5(3.6)	3(2.1)	8(2.8)	
	Divorced	1(0.7)	0(0.0)	1(0.4)	
Age (years)	15-29	50(36.2)	29(20.4)	79(28.2)	
	30-44	47(34.1)	62(43.7)	109(38.9)	$X^2 = 9.040$
	45-64	32(23.2)	37(26.1)	69(24.6)	df = 1, $p = 0.029$
	65^+	9(6.5)	14(9.9)	23(8.2)	
	Mean age	37.2	41.4	39.3	
Education level	No formal education	40(29.0)	41(28.7)	81(28.8)	
	Primary education	86(62.3)	97(67.8)	183(65.1)	$X^2 = 6.356$
	Secondary education	10(7.2)	3(2.1)	13(4.6)	df = 5, $p = 0.273$
	Advanced secondary education	0(0.0)	1(0.7)	1(0.4)	
	Vocational education	1(0.7)	0 (0.0)	1(0.4)	
	Post-secondary education	1(0.7)	1(0.7)	2(0.7)	

Figures in brackets are percentages

Table 2: Service users' awareness about health governance structures (n = 281)

Service users' knowledge about	Bariadi (n = 138)	Itilima (n = 143)	Total (n = 281)
Health facility governing committee	35(25.4)	44(30.8)	79(28.1)
Village health committee	71(51.4)	83(58.0)	154(54.8)
Presence of ordinary citizens in the HFC	34(91.9)	37(88.1)	71(89.9)

Figures in brackets are percentages

and Bariadi, respectively, Simiyu region (6.9) and the national average of 4.8 (URT, 2013a). A large proportion of respondents was married (79%), had attained primary education (65%) and was within the productive age groups. Larger proportion of male respondents (81%) had some form of schooling than their female counterparts (63%). Male respondents also were relatively older (41 years) than female respondents (38 years). Overall, these findings show that the respondents came from diverse socio-demographic backgrounds and could, therefore, be considered as representatives of the different socio-economic groups in the study area.

Service users' awareness about local health governance structures: Service users' awareness about the local health governance structures was assessed by asking service users whether they knew about their existence, presence of community representatives in the structures and how they were selected. This was complemented with district and qualitative data. District data showed that Bariadi district had 21 dispensary committees, 1 health centre committee and a CHSB. In Itilima, there were 27 dispensary committees, 3 health centre committees, but no CHSB. This means that four dispensaries in Bariadi did not have the governing committees whereas Itilima lacked the CHSB. Indeed, existence of the boards and committees could be confirmed from notice boards in villages, wards and health facilities visited and by the fact that the researchers could meet their members. The survey findings show that village health committees were the mostly known health governance structures by more than half of the users (58% in Itilima and 51% in Bariadi), partly because of their local presence at village level. However, only 28% of the service users (31% in Bariadi and 25% in Itilima) were aware of the presence of health facility governing committees (i.e., dispensary and health centre committees). About 90% of these respondents acknowledged that ordinary citizens were represented in the health facility governing committees: 92% in Bariadi and 88% in Itilima (Table 2).

The FGDs and key informant interviews revealed that where more than one health governance structure existed, their roles and responsibilities were often confused or referred to interchangeably. Many respondents confused the village health committees, dispensary committees and community health fund committees. This was partly because of lack of clarity from the perspectives of ordinary community members and service users on how these structures were established and what their functions were. This could mean that service users' awareness about these local structures was limited, especially because they are supposed to be composed of community members, who are expected to represent the service users in the decision-making fora. This could partly be due to the

Table 3: Selection of community members into the health governance structures

Structure	Mode of selection	Bariadi (n = 138)	Itilima (n = 143)	Total (n = 281)
Health facility governing committee	Selected in village assembly	14(37.8)	22(52.4)	36(45.6)
	Nominated by village leaders	8(21.6)	7(16.7)	15(19.0)
	Don't know	15(40.5)	13(31.0)	28(35.4)
Village health committee	Selected in village assembly	32(38.1)	51(62.2)	83(50.0)
	Nominated by village leaders	23(27.4)	9(11.0)	32(19.3)
	Don't know	29(34.5)	22(26.8)	51(30.7)

Figures in brackets are percentages

fact that some of health facilities in the study area lacked any health facility governance committees whereas others had newly established committees that were not functional.

This echoes the findings by Loewenson *et al*. (2004) (cited by McCoy *et al*., 2011) in rural Zimbabwe who found that many people in the community were unaware of health centre committees or their work. The multiplicity of committees at the same administrative level could as well be a challenge. Masanyiwa *et al.* (2013) question the necessity of creating special governing committees for each health facility when village and ward health committees which are linked to local government structures are in place and functioning. Also, as observed by Kessy (2014), these structures tend to work in parallel with each other and the link between them is weak. This arrangement is seen as diluting the relationship between health facilities and the lower local government authorities and sometimes resulting in tensions and conflicts.

The service users had mixed views on how community members were selected into the health governance structures. Less than half (46%) reported that members of the health facility governing committees were selected by village assemblies whereas 19% opined that members were elected by village leaders. The same picture was also revealed regarding how members of the village health committees were selected (Table 3). However, it was worrisome to note that more than one third of the users (35%) did not know how members of the health facility governance committees were selected and another 31% for the village health committees. Impliedly, the limited or poor involvement of village assemblies in selection of health boards and committee members suggests that some of these structures were not democratically elected, thus, did not represent the wider community and service users. In the decentralised local government structure in Tanzania, the village assembly is composed of all adult members in the village, is the major decision-making organ at this level and one of its responsibilities is to elect the village chairperson, village councillors and other committees (Shivji and Peter, 2003). These findings corroborate those of Ramiro *et al*. (2001) who found that although local health boards in the Philippines were meant to become the main mechanisms for broader community participation and governance, there was no democratic consultation in the selection of representatives.

Further, qualitative data from the FGDs and key informant interviews revealed that each health governance structure was established in a different way, sometimes without observing the national guidelines. In one village, the dispensary committee members told us that: 'We were selected by community members in a village assembly'. In another, village leaders reported that: 'we have never received any guidelines on how to establish the village health committee. We used our experience to form this committee'. Consequently, the village health committee in this village was established by village leaders who nominated one representative from each *kitongoji*. Yet, in another village, the dispensary in-charge had decided to establish a dispensary committee without using any guidelines. Whereas the guidelines and legal instruments establishing the boards and committees stipulate the procedures and process to be followed in selecting the members, their composition, tenure and qualifications of the members (URT, 2001; 2013b), these findings show that such guidelines were not adequately observed at the sub-district level. This could mean that without community representatives on the committees, the essence of community participation was impaired. Thus, it was unlikely that the expected benefits of the boards and committees could be achieved. Similar community representative selection problems were also reported in an earlier study by Boon (2007) in two districts in Tanzania, which seem not to have improved over the past one decade.

Level of community engagement and functionality of the structures: The level of community engagement was measured by asking service users whether had attended any village meetings where health issues were discussed, whether were free to express their views and if they felt that their views were taken seriously. The findings show that over the past one year, about half of the service users had attended at least one village meeting where health issues were discussed (52% in Itilima and 47% in Bariadi). Of those who had attended the public meetings, three quarters (75%) in Itilima and most of them (82%) in Bariadi felt free to express their views, suggestions and concerns in the public meetings. Majority of the respondents (57% in Itilima and 67% in Bariadi) felt that their views and suggestions were considered in improving health services delivery in their areas (Table 4). Larger proportions of men (54% in Itilima and 66% in Bariadi) than women (51% in

Table 4: Community participation in health services management

Mode of participation	Bariadi (n = 138)			Itilima (n = 143)		
	Male	Female	Both	Male	Female	Both
Attendance in village meetings that discussed health issues	37(66.1)	28(34.6)	65(47.4)	39 (54.2)	36(50.7)	75(52.4)
Felt free to express views, suggestions or concerns	29(78.4)	24(85.7)	53(81.5)	35(89.7)	21(58.3)	56(74.7)
Views and suggestions considered	24(66.7)	10(47.7)	34(56.7)	22(68.8)	16(64.0)	38(66.7)

Figures in brackets are percentages

Table 5: Composition of health governance structures

Governance structure	Village/ward/health facility	Composition by gender			
		Male	Female	Total	Female %
Village health committees	Mwamtani	4	3	7	42.9
	Sawida	5	3	8	37.5
	Mwamondi	6	2	8	25.0
	Byuna	4	2	6	33.3
	Ikungulyambeshi	4	3	7	42.9
Ward health committee	Nkoma	5	2	7	28.6
Dispensary committees	Sawida	6	2	8	25.0
	Ikungulyambeshi	4	2	6	33.3
Health centre committees	Nkoma	5	2	7	28.6
	Byuna	4	4	8	50.0

Itilima and 35% in Bariadi) reported to have had attended the public meetings. Likewise, more men (90%) than women (58%) in Itilima felt free to express their views, suggestions and concerns in the meetings. Poor community attendance in meetings is widespread including in other countries. In Uganda, low attendance in community meetings was associated with the perceptions that decisions in such meetings are a prerogative of village leaders (Francis and James, 2003) and that meetings at village level do not happen as frequently as they should (Devas and Grant, 2003). These issues were also raised in this study, thus, undermining the role of community meetings as important spaces for participation at the local level.

Functionality of health governance structures was examined in terms of composition of the structures, frequency and attendance in meetings and their engagement in health services planning and management. Information obtained from the health governance structures that participated in this study shows that their composition varied across the villages and health facilities, both numerically and in terms of the groups represented in the structures. Whereas the national guidelines stipulate that dispensary committees should have eight members, including three service users, one of the observed two committees had six members. A similar pattern was observed regarding the composition of health centre committees. Further, the proportion of women in the structures ranged from 25% to 43% in village health committees, 25% to 29% in dispensary committees and 29% to 50% in health centre committees (Table 5). This reflects the earlier observation in this study about non-adherence to the guidelines and legal instruments establishing the boards and committees (URT, 2001; 2013b).

It was further established that almost all the health governance structures did not have regular meetings or had never met at all, since they were established. Thus, it was difficult to ascertain the frequency and attendance of their members in the meetings. The FGD participants and key informants told us that, many members of the health governance structures did not see the importance of these structures in the provision of health services. In addition, the guidelines for establishing and operations of the health governance structures, including the frequency of meetings, were not available at the village, ward and health facility levels. In Mbarali district of Tanzania, Maluka *et al*. (2010) showed that effectiveness of most of committees was perceived as low, almost non-functional and that the committees were suspended because there were no meetings.

In this study, although most of the village health committees' members seemed to be aware of their roles and responsibilities especially those related to community sensitization on health and sanitation issues, none of the health governance structures interviewed had been trained. Thus, they lacked the competencies to effectively execute their mandated functions. Limited capacity because of inadequate training provided to the boards and committees after selection is a fundamental problem which limits their capacity to deliver on the responsibilities as required by the guidelines (Kessy, 2014).

While acknowledging these shortcomings, the health facility in-charges viewed these structures as crucial in health service delivery. They stated that members of village health committees were particularly useful in sensitizing community members on improved sanitation practices, sensitizing pregnant and lactating mothers to utilize ante-natal and post-natal services and assisting in outreach services especially in villages and *vitongoji* without health facilities. In one village, the health facility in charge and members of the dispensary

committee reported that the committee also participated in receiving drugs from the Medical Stores Department. However, there was no evidence of the community health structures participation in health planning, which was perceived as technical by both committee members and health staff. These findings, therefore, show limited community engagement in health planning and management through the health governance structures, which did not seem to be representative of the communities and did not function effectively.

Contextual factors affecting the functionality of health governance structures: The FGDs and key informant interviews revealed a number contextual factors affecting the functionality of local health governance structures. The procedures for establishing and selection of community members into the health governance structures were reported as not clearly understood by the stakeholders at the ward, village and health facility levels. Despite the existence of the guidelines at the council level, it was found that ward and village leaders and health facility in-charges did not know them. Therefore, they did not observe them in the process of establishing the health governance structures. As a result, community representatives in these decision-making organs did not necessarily represent the views of service users because they did not have 'constituencies' to represent. In turn, the community was in most cases not informed on what was decided in the boards and committees as committee members lacked platforms for meetings for feedback and sharing of experiences, an issue also noted by Kessy (2014). In Australia, Nathan *et al*. (2010) found that community members in the health committees were not able to widely represent the wider views of patients or community.

Further, there was limited knowledge and skills of community members in the health governance structures, especially about their roles and functions in the health facility committees which tended to be dominated by health staff. This was partly because community engagement in these structures was not well clarified in the legal guidelines. This impaired the decision-making processes at the district and health facility levels and, hence, the functionality of these structures. Since the role of community members were not clearly defined in these boards, it was difficult for them to exercise their decision-making powers in the management of resources available for health services delivery at both district and health facility levels. This mirrors what was observed by Loewenson *et al*. (2004) (cited by McCoy *et al*., 2011) in rural Zimbabwe where health centre committees were reported as having little or no direct influence over core health budgets or over how clinics were managed and run.

Moreover, in principle all health facility governing committees were required to present their plans to the CHMTs, which include members of the CHSBs. In practice, however, actual involvement of health facility governing committees in health planning was ad hoc and mainly based on consultations by the CHMTs. This means that health facility governing committees did not have influence on the planning, budgeting and expenditure, including the community health fund, partly because they did not meet regularly. This could imply that the concerns and needs of the community members, the service users, were not adequately considered in the process of preparing the CCHPs, which is the main planning and budgeting instrument for health interventions and in the management of the funds. At village and ward levels, the consolidation of village and ward plans (including health issues) was mainly done by the village councils and ward development committees, respectively. The national guidelines provide for members from the ward development committees and other local government structures to be represented in the health governance structures (URT, 2001; 2013b). However, many of the observed health governance structures were established without adhering to the national guidelines suggesting that most of the boards and committees' members lacked the political space to influence the planning and budgeting processes because they did not belong to the local level decision-making and planning structures. In this case, members in the boards and committees were more likely to function rather as individuals than as representatives of particular group having an interest in health care services (Boon, 2007). This defeats the purpose of establishing these local structures that aimed to enhance of community participation in planning and budgeting processes, as well as in the implementation of programs to improve access to quality health services and outcomes (Kessy, 2014).

In addition, the split of the former Bariadi District Council into the current three councils (Bariadi Town Council, Bariadi District Council and Itilima District Council) also affected the functionality of health governance structures, especially the CHSBs. In theory, the goal of the D by D policy, in which the split and formation of new administrative councils is part of, is to bring services closer to the people, the service users. In practice, however, there were delays in putting in place some of the local structures that could contribute towards achieving this goal. For instance, Itilima district had not formed the CHSB almost three years after its establishment and the one in Bariadi was literally not functional since it had never met since the split. Delays in forming or replacing boards and committees after expiry of their tenure have also been reported in other LGAs in Tanzania. For example, Boon (2007) observed a long gap between the selection of the members and the start of the committees, where in some cases extended up to two years and Kessy (2014) reported delays in forming new boards and committees or replacing old ones up to one year.

CONCLUSION AND RECOMMENDATIONS

This study has investigated community participation and functionality of the health governance structures at the sub-district levels using the users' perspective. The study found limited community awareness about the existence of health governance because some health facilities lacked any service boards and committees and in some cases community members were not involved in the selection of community representatives through their village assemblies. Most of the community health governance structures were not functional as they held meetings infrequently and with varied composition contrary to what is stipulated in the guidelines for their establishment. Consequently, community engagement in these structures was very limited. The factors affecting functionality of these structures were: Lack of clarity among stakeholders on the procedures for establishing the structures and limited knowledge and skills of community members on their roles and responsibilities in the health governance structures. There were also delays in establishing and replacing expired service boards and committees, thus, defeating the purpose of improving health service delivery through improved community participation and governance. It is recommended that district councils should strengthen the health governance structures to function effectively as stipulated in the guideline for their establishment. This could entail creating awareness among stakeholders especially at the ward, village and health facility levels about the guidelines for establishing and functioning of the health governance structures.

REFERENCES

Boon, S., 2007. How Not to Decentralise: Accountability and Representation in Health Boards in Tanzania. The Hague, SNV.

Brinkerhoff, D.W., 2012. Community Engagement in Health Services Delivery and Governance: Experience from the Philippines. Proceeding of the International Institute of Administrative Sciences, 2012 International Congress Merida, Mexico June 18-22, 2012.

Conyers, D., 2007. Decentralisation and service delivery: Lessons from sub? Saharan Africa. IDS Bull., 38(1): 18-32.

Devas, N. and U. Grant, 2003. Local decision making-Citizens participation and local accountability: Some evidence from Kenya and Uganda. Pub. Administ. Develop., 23(4): 307-316.

Dodgson, R., K. Lee and N. Drager, 2002. Global Health Governance: A Conceptual Review. Discussion Paper No.1. Centre on Global Change and Health, London School of Hygiene Tropical Medicine.

Francis, P. and R. James, 2003. Balancing rural poverty reduction and citizen participation: The contradictions of Uganda's decentralization program. World Develop., 31(2): 325-337.

Grinnell, R.M., 2001. Social Work Research and Evaluation: Quantitative and Qualitative Approaches. 6th Edn., Thomson Brooks/Cole, Belmont.

Kessy, F.L., 2014. Improving health services through community participation in health governance structures in Tanzania. J. Rural Commun. Develop., 9(2): 14-31.

Loewenson, R., I. Rusike and M. Zulu, 2004. Assessing the impact of Health Centre Committees on health system performance and health resource allocation. EQUINET Discussion Paper 18. Harare, Zimbabwe: EQUINET.

Lynch, S.M., 2013. Using Statistics in Social Research. Princeton University, New Jersey.

Maluka, S., P. Kamuzora, M.S. Sebastiån, J. Byskov, T.E. Olsen, E. Shayo and A.K. Hurtig, 2010. Decentralized health care priority-setting in Tanzania: Evaluating against the accountability for reasonableness framework. Soc. Sci. Med., 71(4): -751-759.

Masanyiwa, Z.S., A. Niehof and C.J.A.M. Termeer, 2013. Institutional arrangements for decentralized water and health services delivery in rural Tanzania: Differences and constraints. Basic Res. J. Soc. Pol. Sci., 1(4): 77-88.

Masanyiwa, Z.S., A. Niehof and C.J. Termeer, 2015. A gendered users' perspective on decentralized primary health services in Rural Tanzania. Int. J. Health Plann. Manage., 30(3): 285-306.

McCoy, D.C., J.A. Hall and M. Ridge, 2011. A systematic review of the literature for evidence on health facility committees in low-and middle-income countries. Health Pol. Plann., 27(6): 449-466.

Nathan, S., L. Johnston and J. Braithwaite, 2010. The role of community representatives on health service committees: Staff expectations vs. reality. Health Expect., 14(3): 272-284.

Ramiro, L.S., F.A Castillo, T. Tan-Torres, C.E. Torres, J.G. Tayag, R.G. Talampas and L. Hawken, 2001. Community participation in local health boards in a decentralized setting: Cases from the Philippines. Health Pol. Plann., 16(Suppl 2): 61-69.

Saltman, R., V. Bankauskaite and K. Vrangbaek, 2007. Decentralisation in health care: Strategies and outcomes. European Observatory on Health Services Systems and Policies Series. Open University Press, Berkshire, Mc Graw Hill.

Shivji, I.G. and C.M. Peter, 2003. Village Democracy Initiative Report. President's Office-Regional Administration and Local Government, Dodoma.

URT (United Republic of Tanzania), 2001. The District Council (Council Health Service Board Establishment) Instrument, 2001. Ministry of Health, Dar es Salaam.

URT (United Republic of Tanzania), 2007. Primary Health Services Development Programme (PHSDP) 2007-2017. Ministry of Health and Social Welfare, Dar es Salaam.

URT (United Republic of Tanzania), 2013a. 2012 Population and Housing Census: Population Distribution by Administrativer Areas. National Bureau of Stastics, Ministry of Finance, Dar es Salaam.

URT (United Republic of Tanzania), 2013b. Mwongozo wa Uundaji na Uendeshaji wa Bodi za Huduma za Afya za Halmashauri na Kamati za Usimamizi za Hospitali, Vituo vya Afya na Zahanati Nchini Tanzania. Wizara ya Afya na Ustawi wa Jamii, Dar es Salaam.

URT (United Republic of Tanzania), 2016. Tanzania and demographic health survey and malaria indicator survey 2015-16. National Bureau of Statistics, Dar es Salaam.

Vlassoff, C. and C.G. Moreno, 2002. Placing gender at the centre of health programming: Challenges and limitations. Soc. Sci. Med., 54(11): 1713-1723.

WHO, 1978. Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

WHO, 2017. WHO community engagement framework for quality, people-centred and resilient health services. World Health Organization, Geneva.